

<i>SERFF Tracking Number:</i>	<i>FRCS-125834402</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Knights of Columbus</i>	<i>State Tracking Number:</i>	<i>40448</i>
<i>Company Tracking Number:</i>	<i>4976</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Change, Conversion/Exchange Apps</i>		
<i>Project Name/Number:</i>	<i>KOFC/131/131</i>		

Filing at a Glance

Company: Knights of Columbus

Product Name: Change, Conversion/Exchange SERFF Tr Num: FRCS-125834402 State: ArkansasLH

Apps

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 40448

Sub-TOI: L08.000 Life - Other

Co Tr Num: 4976

State Status: Approved-Closed

Filing Type: Form

Co Status: None

Reviewer(s): Linda Bird

Author: LaToya Osborn

Disposition Date: 10/10/2008

Date Submitted: 10/03/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: KOFC/131

Status of Filing in Domicile: Pending

Project Number: 131

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Submitted on or about this same date.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/10/2008

State Status Changed: 10/10/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Our fee of \$60 has been sent by EFT on this same date.

The Knights of Columbus is a fraternal benefit society.

These forms are new and are not intended to replace any previously approved form.

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The Request for Conversion/Exchange Application, form 550-AR CONV-EX 1-08, will be used when an existing policyholder wishes to convert or exchange his policy to another policy offered by the Knights of Columbus.

The Policy Change Form, form 551-AR POLICY CHANGE 1-08, will be used when an existing policyholder wishes to change a benefit or option of his policy.

The Declaration of Insurability Application, form 550-AR DOI 1-08, will be used in conjunction with either of the applications above when medical information is necessary to underwrite the conversion, exchange or change. This application form will never be used by itself.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

If you have any questions or need additional information, please call toll-free 1-800-927-2730. Thank you for your assistance.

Company and Contact

Filing Contact Information

(This filing was made by a third party - FC01)

LaToya Osborn, Technician	latoya.osborn@firstconsulting.com
1020 Central	(800) 927-2730 [Phone]
Kansas City, MO 64105	(816) 391-2755[FAX]

Filing Company Information

Knights of Columbus	CoCode: 58033	State of Domicile: Connecticut
1 Columbus Plaza	Group Code:	Company Type:
New Haven, CT 06507-3326	Group Name:	State ID Number:
(203) 752-4266 ext. [Phone]	FEIN Number: 06-0416470	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$60.00
Retaliatory?	No

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Fee Explanation:	AR fee of \$20 per filing=\$60.		
Per Company:	No		

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Knights of Columbus	\$60.00	10/03/2008	22912966

SERFF Tracking Number:	FRCS-125834402	State:	Arkansas
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TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	Change, Conversion/Exchange Apps		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/10/2008	10/10/2008

<i>SERFF Tracking Number:</i>	<i>FRCS-125834402</i>	<i>State:</i>	<i>Arkansas</i>
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Disposition

Disposition Date: 10/10/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	FRCS-125834402	State:	Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Form	Request for Conversion/Exchange Application		Yes
Form	Policy Change Form		Yes
Form	Declaration of Insurability Application		Yes

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Form Schedule

Lead Form Number: 550-AR CONV-EX 1-08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	550-AR CONV-EX 1-08	Application/ Request for Enrollment Form	Conversion/Exchange Application	Initial		53	550-AR CONV-EX 1-08_distilled.pdf
	551-AR POLICY CHANGE 1-08	Application/ Policy Change Form	Enrollment Form	Initial		55	551-AR 1-08_distilled.pdf
	550-AR DOI 1-08	Application/ Declaration of Enrollment Form	Insurability Application	Initial		63	550-AR DOI 1-08_distilled.pdf

Home Office Use

KNIGHTS OF COLUMBUS
A FRATERNAL BENEFIT SOCIETY
1 Columbus Plaza
New Haven, CT 06510-3326
Telephone Number: (800) 524-3611
REQUEST FOR CONVERSION/EXCHANGE

Use space below for plate or Agent's name and code. (This is for General Agent's use only.)

☐ **CONVERSION** ☐ **EXCHANGE**

Contract Number(s) _____

INFORMATION CONCERNING PROPOSED INSURED

PRINT ANSWERS TO ALL QUESTIONS.

1. (a) Legal Name: (last-first-middle initial) (b) Sex _____

2. (a) Council No. (b) Membership No. (c) Social Insurance No. _____

3. (a) Date of birth: (mo. day yr.) _____

4. Address Street _____

City Province Postal Code _____

5. (a) Issue Age: (b) Place of Birth: _____

(a) Telephone No. (Day): (____) _____

(b) Telephone No. (Evening): (____) _____

(c) Email Address: _____

Owner: Unless otherwise designated below, the owner of adult insurance is the proposed insured and the owner of juvenile insurance is the applicant. In the event of the death of the owner prior to the termination of the Contract, ownership shall pass to the contingent owner designated below:

Owner _____

Relationship to Insured _____

Address of Owner _____

City Province Postal Code _____

Social Insurance Number of Owner _____

Contingent Owner: _____

Payor:

Premium Payor's name and Address, if different from Owner:
(For EFT/MAC, please use name on voided check.)

6. 10. Premium Payable: \$ _____
\$ _____ Amount Paid If even dollar premium,
Herewith: ☐ check here and indicate
no amount in section 12.

☐ Ann. ☐ M.A.C./E.F.T. **Withdrawal Day:** _____
Existing MAC Policy (ies) _____

☐ S.A. ☐ Military Allotment (branch of service) _____

☐ Q.A. ☐ Combined Billing ☐ Salary Deduction

7A. TYPE: ☐ **Conversion (Term to Life)**

****Sections 8 & 9 must be completed.**

**** IF ALLOWED**

- ☐ Total Term Policy
☐ Partial Term Policy (Retain balance) **
☐ Partial Term Policy (Drop balance)
☐ Total _____ Term Rider
☐ Partial _____ Term Rider (Retain balance) **
☐ Partial _____ Term Rider (Drop balance)
☐ Children's Insurance Rider

Requested Register Date if permitted _____

7B. TYPE: ☐ **Internal Exchange (Term to Term; Life to Term, Life to Life)** ****Proper Replacement forms must be submitted. Requested Register Date** _____

8. (a) Plan Description: _____
(b) Plan Code: _____

9. **Face Amount:** \$ _____
If even dollar premium, leave blank.

10. Indicate riders to be included:

- ☐ Waiver of Premium
- ☐ Accidental Death \$_____ Amount
- ☐ Guaranteed Purchase Option \$_____ Amount
- ☐ Payor Benefit (juvenile contract only)
- ☐ Ten Year Level Term \$_____ Amount (Insured)
- ☐ Ten Year Level Term \$_____ Amount (Spouse)
- ☐ IPR _____ Yrs. _____ Units (Insured)
- ☐ IPR _____ Yrs _____ Units (Spouse)
- ☐ SDPUA Rider \$ _____ Amount
- ☐ 20 Year Level Term \$_____ Amount (Insured)
- ☐ 20 Year Level Term \$_____ Amount (Spouse)
- ☐ Additional Protection Benefit \$_____ Amount
- ☐ BGPO \$_____ Amount
- ☐ Spouse's Contract's Waiver of Premium Rider
- ☐ Youth Purchase Option Rider \$_____ Amount
- ☐ Other Rider _____
- ☐ Other Rider _____

11. Any dividends payable under the insurance contract hereby applied for are to be:

- | | |
|--|---|
| <input type="checkbox"/> Paid in Cash | <input type="checkbox"/> Applied to purchase |
| <input type="checkbox"/> Applied to Reduce Premium | <input type="checkbox"/> Paid-Up Additions |
| <input type="checkbox"/> Held at Interest | <input type="checkbox"/> Paid-Up Additions used as Inside Additions |

12. In event of a default in payment of any premium due on the insurance contract issued, shall the automatic premium loan provision, if applicable, be effective in lieu of any nonforfeiture option?

Yes ☐ No ☐

13. Beneficiary -- May Complete Form 113A.

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Unless otherwise directed, beneficiaries for insurance provided Child Rider are stated in rider.

14. Remarks:

It is understood and agreed that: (1) Except as provided under a Temporary Insurance Agreement, this change will take effect only after this request is approved by the Knights of Columbus and any required payment is made; and (2) the Charter, Constitution and Laws of the Knights of Columbus now in effect or hereinafter enacted shall be binding upon the proposed insured, the policy owner and the beneficiary.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Witness _____
Signature of Writing Agent Name

Signed at _____
City Province Postal Code

Writing Agent's ID Number

this _____ day of _____ 20____

Signature of Insured

Signature of Policy Owner/Spouse/Irrevocable Beneficiary

KNIGHTS OF COLUMBUS
A FRATERNAL BENEFIT SOCIETY
1 Columbus Plaza
New Haven, CT 06510-3326
Telephone Number: (800) 524-3611

Use space below for plate or Agent's name and code.
(This is for General Agent's use only.)

POLICY CHANGE FORM

Policy Number(s): _____

PRINT ANSWERS TO ALL QUESTIONS.

1. Name of Insured: (last-first-middle initial) _____

2. (a) Council No. (b) Membership No. (c) Social Security No. _____

3. (a) Date of birth: (mo. day yr.) _____

4. Address _____ Street _____

City _____ State _____ Zip Code _____

(a) Telephone No. (Day): (____) _____

(b) Telephone No. (Evening): (____) _____

(c) Email Address: _____

Section I.

PLAN CHANGE: (Retains original Register Date. All other elements and features of the Contract will remain unchanged.)

Change Plan of Insurance to _____

Change Plan to: ☐ Non-Tobacco**

☐ Reduce from Ultimate Rates to Select Rates **
(Re-Entry Provision Only On Applicable Contracts)

**** FOR THESE ADJUSTMENTS PLEASE COMPLETE A
550 DOI ON ALL PROPOSED INSUREDS.**

Section II.
REDUCTION OF COVERAGE OR SUBSTANDARD RATING:

- ☐ Reduce Face amount of basic Contract to \$ _____
- ☐ Reduce Decreasing Term Rider to \$ _____
- ☐ Reduce Additional Protection Benefit to \$ _____
- ☐ Reduce Level Term Rider (Insured) to \$ _____
- ☐ Reduce Level Term Rider (Spouse) to \$ _____
- ☐ Reduce Income Protection Rider (Insured) to \$ _____
- ☐ Reduce Income Protection Rider (Spouse) to \$ _____
- ☐ Reduce Children's Insurance Rider to _____ Units
- ☐ Reduce Face amount of _____ to _____
- ☐ Reduce/Remove Substandard Rating**
- ☐ Other _____
- ☐ Other _____

Section III. ADDITIONS **

- ☐ Waiver of Premium
- ☐ Accidental Death \$ _____ Amount
- ☐ Guaranteed Purchase Option \$ _____ Amount
- ☐ Child Rider \$ _____ Amount
- ☐ BGPO \$ _____ Amount
- ☐ Youth Purchase Option Rider \$ _____ Amount
- ☐ Payor Benefit (juvenile contract only)
- ☐ Other _____
- ☐ Other _____

Section IV. REMOVALS

- | | |
|--|---|
| <input type="checkbox"/> Waiver of Premium | <input type="checkbox"/> Income Protection Rider (Insured) |
| <input type="checkbox"/> Accidental Death | <input type="checkbox"/> Income Protection Rider (Spouse) |
| <input type="checkbox"/> Guaranteed Purchase Option | <input type="checkbox"/> Children's Insurance Rider |
| <input type="checkbox"/> Decreasing Term | <input type="checkbox"/> Additional Protection Benefit |
| <input type="checkbox"/> Spouse's contract's Waiver of Premium rider | <input type="checkbox"/> BGPO |
| <input type="checkbox"/> Ten Year Level Term (Insured) | <input type="checkbox"/> Youth Purchase Option Rider |
| <input type="checkbox"/> Ten Year Level Term (Spouse) | <input type="checkbox"/> Payor Benefit (juvenile contract only) – |
| <input type="checkbox"/> 20 Year Level Term (Insured) | <input type="checkbox"/> Other Rider _____ |
| <input type="checkbox"/> 20 Year Level Term (Spouse) | <input type="checkbox"/> Other Rider _____ |

Section V. ☐ ELECTION OF REDUCED PAID UP INSURANCE:

Effective as of the date to which premiums are paid; the Contract is to be continued as participating paid up insurance for a Reduced amount. It is understood that any riders or provisions attached to this Contract which provide for any additional benefits over and above those provided by the Contract itself will be cancelled as of the date of conversion to paid up insurance for a reduced amount. **Election of Reduced Paid Up Insurance may result in a taxable gain.**

Section VI. ☐ ELECTION OF EXTENDED TERM INSURANCE:

Effective as of the date to which premium are paid, the Contract is to be continued as non-participating extended term insurance for its face amount less any indebtedness in accordance with the conditions stated in the Contract. It is understood that any riders or provisions attached to this Contract which provide for any additional benefits over and above those provided by the Contract itself, will be cancelled as of the date of conversion to extended term insurance.

Section VII. ☐ SPECIAL REQUEST OR REMARKS: (Give details of any changes not covered elsewhere.)

It is understood and agreed that: (1) Except as provided under a Temporary Insurance Agreement this Contract change will take effect only after this request is approved by the Knights of Columbus and any required payment is made; and (2) the Charter, Constitution and Laws of the Knights of Columbus now in effect or hereinafter enacted shall be binding upon the proposed insured, the Contract owner and the beneficiary.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Witness _____
Signature of Writing Agent

Writing Agent's ID Number

Signed at _____
City State Zip Code

This _____ day of _____ 20____
month year

Signature of Insured

Signature of Contract Owner/Spouse/Irrevocable Beneficiary

Policy No. _____
 Name _____

KNIGHTS OF COLUMBUS
A FRATERNAL BENEFIT SOCIETY
 1 Columbus Plaza
 New Haven, CT 06510-3326
DECLARATION OF INSURABILITY

☐ Medical Required

1. List proposed insured and, if applicable, payor (for Payor Benefit Rider only), spouse, children and stepchildren under 18 years of age. Attach a separate sheet, if needed. All questions must be answered for each person listed below.

First Name	Sex	Date of Birth	Height	Weight	Total Insurance in Force
Proposed Insured					
Payor (If Payor Benefit is applied for.)					
Spouse					

First Name	Sex	Date of Birth	Height	Weight	Total Insurance in Force
Child					
Child					
Child					

2. Has any person named in Question 1 ever used tobacco or tobacco substitutes? Yes ☐ No ☐
 If yes, give dates of last use below. Proposed Insured(s) initial here _____.

Cigarettes mo. ____ yr. ____	Cigars mo. ____ yr. ____	Pipe mo. ____ yr. ____	Snuff mo. ____ yr. ____	Chewing Tobacco mo. ____ yr. ____	Patch, gum or any nicotine substitute mo. ____ yr. ____
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All Questions must be answered for each individual listed in Question 1.	Yes	No	Give details below for "yes" answers, including question number and person. If needed, use the space provided in number 12 or an attached separate sheet.
3. a. Are there any existing life insurance or annuity contracts on the life of the proposed insured?			
b. Is the insurance applied for intended to replace any existing insurance or annuities with the Knights of Columbus or another insurer?			
c. If the answer to either question is yes, please complete Section 14.			
4. a. Are negotiations now pending for life or health insurance on any of the proposed insureds?			
b. Has any proposed insured been declined, postponed or rated for life or health insurance or reinstatement thereof?			
c. Has any proposed insured ever made claim for sickness, accident or pension benefits?			
d. Has any life, accident or health insurance policy issued on any proposed insured been cancelled by the issuer or the renewal thereof been refused?			
5. a. Is any proposed insured contemplating making or in the past three years has any proposed insured made flights as a pilot, student pilot, crew member, or flights in other than commercial planes? (If yes, complete Aviation Questionnaire 561.)			
b. Is any proposed insured contemplating engaging in or in the past three years has any proposed insured engaged in any type of scuba diving or sky diving, racing, rodeo activities or hang gliding? (If yes, complete questionnaire.)			

All Questions must be answered for each individual listed in Question 1.	Yes	No	Give details below for "yes" answers, including question number and person. If needed, use the space provided in number 12 or an attached separate sheet.
c. Has any proposed insured recently traveled overseas, or is foreign travel planned or contemplated?			
6. Has any person named in Question 1 ever received treatment, attention or advice from any physician or other practitioner for, or been told by any physician or other practitioner that such person has or had:			
a. Tuberculosis, asthma, emphysema, COPD, pneumonia or other lung disease or disorder?			
b. Stroke, fainting spells, epilepsy, paralysis, depression or mental disorder, dementia, Alzheimer's, autism, nervous system or other brain disorder?			
c. Ulcers, colitis, rectal disorder, indigestion or other disorder of the esophagus, stomach, intestines, liver or gall bladder?			
d. Cancer, tumors, disorder of the blood or lymph glands, or endocrine disorder?			
e. Diabetes, sugar, albumin, pus, or blood in the urine or other kidney or bladder disorder?			
f. Disease of the heart or blood vessels, chest pains, shortness of breath, heart enlargement, high or low blood pressure, abnormal heart rhythm or palpitations?			
g. Arthritis, gout, multiple sclerosis, or disorder of the muscles or bones?			
h. Disease or disorder of the ears, eyes, nose or throat?			
i. Disorder of the prostate, reproductive organs or breasts?			
7. Has any person named in Question 1 received treatment from any physician, or other practitioner for, or been told by any physician, other practitioner, or counselor that such person has or had, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any Disorder of the immune system?			
8. Has any person named in Question 1 been hospitalized or consulted a physician or suffered from any illness, disease or syndrome not listed above, or is any such person taking any medication not previously listed?			
9. Has any person named in Question 1 ever been advised by a health professional to seek treatment for, been treated for the excessive use of alcohol, narcotics or other habit forming drugs or been convicted of or plead guilty to a drug or alcohol related offense?			
10. Within the past five years, has any person named in Question 1 had a license suspended or had a moving traffic violation? (a) Driver's License _____ (b) State of License _____			

11. Primary Care Physicians or Health Facilities:

Name of Primary Care Physician or Facility	Name of Specialist
Street Address	Street Address
CityStateZip Code	CityStateZip Code
Telephone Number	Telephone Number
Date last seen: Reason last seen:	Date last seen: Reason last seen:

12. Additional remarks in answer to Questions 3 – 11:

13. All Present Occupations:	Exact Duties in Each:

14. List all life insurance, annuities and long term care policies on any proposed insured (including pending applications and reinstatements).

Company/Person Insured	Face Amount	Accidental Death Amount	Year Issued	List Contract Number if K. of C.

15. Family history: (any history of diabetes, cancer, high blood pressure, heart, kidney disorder, mental illness or suicide),

	Age	If Living State of Health (if poor, give reason)	If Deceased Age at Death	If Deceased Cause of Death
Father				
Mother				
Brothers and Sisters				

16. Citizenship: ☐ United States ☐ Canada (provide SIN) ☐ Other (provide country and tax I.D. number)

- (1) I agree that the statements and answers contained in this Declaration of Insurability are representations and not warranties and are complete and true to the best of my knowledge and belief. **The Knights of Columbus shall not be bound by any information that is not set out in writing in this Declaration of Insurability.**
- (2) I agree that the Charter, Constitution and Laws of the Knights of Columbus now in effect or hereafter enacted shall be binding upon me and the beneficiary.
- (3) I agree that, except for coverage which may be provided in the Temporary Insurance Agreement, no insurance will be in force because of this Declaration of Insurability until it has been approved and the minimum required premium has been paid to the Knights of Columbus.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____ this _____ day of _____,
City State Zip Code Year

Applicant's Signature _____ Proposed Insured's Signature _____
(If other than applicant)

Spouse's Signature _____ Owner's Signature _____
If covered under rider (If other than applicant or proposed insured)

Witness _____
Signature and ID Number of Writing Agent

Does the proposed insured have any existing life insurance or annuity contracts? ____ Yes ____ No.

Has any life insurance or annuity contract either in force or applied for on the life of the proposed insured terminated or is termination of such insurance or annuity contemplated as a result of the issuance of the life insurance contract applied for? Yes ☐ No. ☐

If the answer to either question is yes, have you complied with the requirements of the Order and your state with regard to this replacement? Yes ☐ No ☐ (Give full details)

Date: _____

Signature of Writing Agent and Agent Number

() _____
Writing Agent's Telephone Number

AGENT'S REMARKS _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A) To assist the Knights of Columbus in underwriting my Request for Conversion/Exchange or Policy Change Form, I hereby authorize those persons or organizations listed in section B of this Authorization who possess medical or non-medical information concerning me or my children and stepchildren to permit the Knights of Columbus or its representatives, including, but not limited to: physicians, paramedics, teleunderwriters and consumer reporting agencies; to view, to copy, to be furnished a copy or to be given details of all such information. In addition to other medical or non-medical information, this Authorization applies to any information about psychiatric, drug or alcohol abuse treatment. **Please note that the term "non-medical information" consists of information obtained from a consumer investigative report which would pertain to such items as: confirmation of age, residence, marital status, employment, information as to character, general reputation, personal characteristics, avocation and mode of living.**

B) Those persons or organizations authorized to disclose medical or non-medical information concerning me or my children and stepchildren are: licensed physicians, medical practitioners, paramedics, teleunderwriters, hospitals, clinics or other medical or medically related facilities, government agencies regulating motor vehicles, insurance and reinsurance companies, consumer reporting agencies and the Medical Information Bureau.

C) Notwithstanding the provisions of sections A and B of this Authorization, the Medical Information Bureau may release information only to the Knights of Columbus.

D) I also authorize the Knights of Columbus to release any information regarding me, my children and stepchildren or our health to: the Medical Information Bureau; any company to which my Request for Conversion/Exchange or Policy Change Form is submitted for reinsurance purposes; my Knights of Columbus agents; and to other life insurance companies with whom I have policies or to whom I may apply for insurance, or to whom a claim for benefits may be submitted.

E) I authorize the Knights of Columbus to obtain an investigative consumer report on me. I understand that I may request to be interviewed in connection with the preparation of such a report.

F) I acknowledge receiving and reading the notices regarding the Fair Credit Reporting Act, the Medical Information Bureau and Description of Information Practices and Fraud Warning.

G) This Authorization expires two years from the date shown below unless sooner revoked by writing to us at P.O. Box 1670, New Haven, Connecticut 06510-3326. A photocopy of this signed Authorization shall have the same validity as the original. I understand that I am entitled to receive a copy of this Authorization.

Signature _____
(Parent if proposed insured is under 18)

(Spouse if coverage applied for)

In presence of:

Witness

Date _____

I request that I be interviewed in the event an investigative consumer report is prepared in connection with the application. (Please initial here _____.)

THIS PAGE IS LEFT BLANK INTENTIONALLY.

RECEIPT

The Knights of Columbus received \$ _____ from _____ on the date shown below. This amount was paid when a Request for Conversion/Exchange or Policy Change Form which bears the same date as this Receipt was signed in which _____ is named as the proposed insured. This Receipt and the Temporary Insurance Agreement set forth below are issued on the condition that any check, draft or other order or authorization for payment of money is good and can be collected.

Date: _____ Agent _____

(The above Receipt must not be completed unless payment for the initial premium has been made or unless use of existing Knights of Columbus values has been authorized. The premium check, if any, must be made payable to the Knights of Columbus. Do not make the check payable to the agent or leave the payee blank.)

TEMPORARY INSURANCE AGREEMENT

The Knights of Columbus agrees to provide Temporary Insurance as follows:

Payment of Temporary Insurance

The Temporary Insurance will be paid to the beneficiary named in the Request for Conversion/Exchange or Policy Change Form, if any person who is to be covered by the Additional Coverage applied for dies while the Temporary Insurance is in force. "Additional Coverage" refers to any insurance coverage in excess of that coverage provided under the original policy which is being modified in accordance with the Request for Conversion/Exchange or Policy Change Form.

Amount of Temporary Insurance

This Agreement provides Temporary Insurance for any person who is to be covered by the Additional Coverage, in the amount of the Additional Coverage applied for on that person or \$300,000, whichever is less. (See Special Limitation 1 below.)

Commencement of Temporary Insurance The Temporary Insurance will start when all medical exams, paramedical exams, telemedical exams, laboratory tests and reports required at time of application are completed. If no exams, tests or reports are required, the Temporary Insurance will start at time the Request for Conversion/Exchange or Policy Change Form is signed.

Duration of Temporary Insurance

Unless this Temporary Insurance ends sooner for one of the three reasons listed in the Termination of Temporary Insurance section below, it will end 90 days after it starts.

Termination of Temporary Insurance

1. The Temporary Insurance will end when the Knights of Columbus issues insurance as applied for.
2. The Temporary Insurance will end when the Knights of Columbus issues insurance other than as applied for, and it is accepted by the contract owner.
3. The Temporary Insurance will end when the Knights of Columbus refunds the initial premium or restores the existing values used to pay the initial premium.

Special Limitations Applicable to Temporary insurance Agreement

1. In the event that more than one Temporary Insurance Agreement is in force at the time of a proposed insured's death, the maximum total amount payable under all such Agreements will be \$300,000.
2. If any proposed insured dies by suicide, the liability of the Knight of Columbus under this Agreement is limited to a refund of the payment made.
3. No Temporary Insurance will be provided with respect to a child to be insured under the insurance contract applied for or under a Family Insurance Rider or Children's Insurance Rider, if death occurs while such child is less than 15 days old.
4. No Temporary Insurance will be provided with respect to any proposed insured who is to be insured under an insurance contract applied for under the provisions of a Guaranteed Purchase Option Rider or a Youth Purchase Option Rider.
5. No Temporary Insurance will be provided for any insurance coverage paid for by funds transferred from another insurer as part of a Section 1035 exchange.
6. Fraud or material misrepresentation in the application invalidates this Agreement. In the event of fraud or material misrepresentation, the liability of the Knights of Columbus is limited to a refund of any payment made.
7. No change may be made in the terms and conditions of this Agreement. No statement which claims to make such a change will bind the Knights of Columbus.

NOTICE TO PROPOSED INSURED

Fair Credit Reporting Act

Federal and state laws require us to notify you that, in connection with our consideration of this application, we may request and obtain an investigative consumer report. In addition, such a report may be requested subsequently to update our records. We may also request one, if you apply for more coverage.

The report may contain information as to character, general reputation, personal characteristics and mode of living and driving record. It may be obtained through an interview with: you, an adult member of your family, friends, neighbors, business associates, other persons with whom you are acquainted, or government agencies regulating motor vehicles. The report will also consist, when applicable, of a confirmation of your age, residence, marital status, employment and the like.

You have the right, upon written request, to be informed whether or not an investigative consumer report was obtained by us. Send your request to: Medical Director, Knights of Columbus, P.O. Box 1670, New Haven, Connecticut 06510-3326. If it was obtained, we are required to furnish the name and address of the consumer reporting agency and to furnish detailed information concerning the nature and scope of the report. Where the name and address of the consumer reporting agency are furnished, the report may be inspected and a copy may be obtained by contacting the agency.

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (MIB)

This MIB is a non-profit organization which operates as an information exchange for its members. The Knights of Columbus is a member of the MIB.

We make reports to the MIB on factors affecting your insurability. We will not inform them of our decision on your applications. If you subsequently apply to another MIB member company for life or health insurance or submit a claim for benefits, the MIB will, upon request, supply that company with information in its files. The Knights of Columbus or its reinsurer(s) may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon written request, the MIB will arrange disclosure of any information it may have on you in its file. If you feel the information in the MIB file is not correct, you may contact the MIB and seek a correction in accordance with procedures outlined in the Federal Fair Credit Reporting Act.

The MIB's address is: MIB, Inc., P.O. Box 105, Essex Station, Boston, Massachusetts 02112. The MIB's telephone number is: (866) 692-6901 (TTY 866-346-3642 for hearing impaired). The MIB's web address is: www.mib.com.

DESCRIPTION OF INFORMATION PRACTICES

Collection of Information

In order to properly underwrite your insurance coverage, we must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending on the amount and type of coverage applied for. In general, we may seek information about: your age, occupation, physical condition, health history, mode of living, avocations and other personal characteristics.

You are our most important source of information, but we may also collect or verify information by contacting: medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone, or by personal contact.

In some cases, we may ask an insurance support organization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosure of Information

In some circumstances, the Knights of Columbus will make disclosures of personal information to third parties. Following is a brief description of some of the persons or organizations to whom certain items of information might be disclosed: the Medical Information Bureau, our reinsurers, our agents, and other insurance companies to which you have applied for coverage or benefits.

The above describes some of the disclosures which may be made, not disclosures which are always or even often made. In any event, the information disclosed will be only as much as is reasonably necessary to accomplish the intended purpose.

Access and Correction

There are procedures by which you can obtain access to personal information about you appearing in our files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request.

Obtaining Additional Information

We hope that you find this description of our information practices helpful. We take our responsibilities, and your rights, very seriously. If you have any further questions about the items just discussed please write to us at: P.O. Box 1670, New Haven, Connecticut 06510-3326.

<i>SERFF Tracking Number:</i>	<i>FRCS-125834402</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Knights of Columbus</i>	<i>State Tracking Number:</i>	<i>40448</i>
<i>Company Tracking Number:</i>	<i>4976</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Change, Conversion/Exchange Apps</i>		
<i>Project Name/Number:</i>	<i>KOFC/131/131</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	FRCS-125834402	State:	Arkansas
Filing Company:	Knights of Columbus	State Tracking Number:	40448
Company Tracking Number:	4976		
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	Change, Conversion/Exchange Apps		
Project Name/Number:	KOFC/131/131		

Supporting Document Schedules

	Review Status:	
Satisfied -Name:	Certification/Notice	09/26/2008
Comments:		
Attachments:		
AR_Coc_dist.pdf		
Auth_10-08_dist.pdf		
AR_Rdb Certification_dist.pdf		


**STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE**

Company Name: Knights of Columbus

Form Title(s): Request for Conversion/Exchange Application
Policy Change Form
Declaration of Insurability Application

Form Number(s): 550-AR CONV-EX 1-08
551-AR POLICY CHANGE 1-08
550-AR DOI 1-08

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Richard B. Carroll
Associate General Counsel

September 26, 2008

Date



KNIGHTS OF COLUMBUS

October 1, 2008


To: Department of Insurance

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Knights of Columbus

By: 


Title: Associate General Counsel

**STATE OF ARKANSAS
READABILITY CERTIFICATION**

COMPANY NAME: Knights of Columbus

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
550-AR CONV-EX 1-08	52.9
551-AR POLICY CHANGE 1-08	55.1
550-AR DOI 1-08	62.7



Richard B. Carroll
Associate General Counsel

September 26, 2008
Date